		ND HUMAN SERVICES				: 06/02/2010 APPROVED
	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l.	ULTIPLE LDING	EXPLORATION 1 1 2010 COMPLETE	ĒD □
	•	185094	B. WIN		Division of Health Care 05/19	9/2010
NAME OF PR	OVIDER OR SUPPLIER			STREE	Southern Enforcement Branch	
SIGNATUR	RE HEALTHCARE OF P	IKEVILLE			SOUTH MAYO TRAIL KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PRES TAC	ax	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	s ·	F	000		
F 312	KY14742) was cond Deficient practice was related to KY14746, identified related to	ARE PROVIDED FOR	F	312	Signature Health Care of Pikeville does believe and does not admit that deficiencies existed, before, during or the survey. The Facility reserves all righ	any after
	A resident who is ur daily living receives	nable to carry out activities of the necessary services to cion, grooming, and personal			contest the survey findings through info dispute resolution formal approceedings or any administrative or proceedings. This plan of correction is meant to establish any standard of contract obligation or position and Facility reserves all rights to raise possible contentions and defenses in	ppeal legal not care, the
	by: Based on observati review, it was deter provide necessary of personal hygiene for Interviews with resirevealed residents hours or more to be	on, interview, and record mined that the facility failed to services to maintain good or each incontinent resident. dents and nursing staff frequently had to wait four (4) a provided with incontinence fficient amount of staff.			type of civil or criminal claim, actio proceeding. Nothing contained in this of correction should considered as a w of any potentially applicable Peer Re Quality assurance or self critical examin privilege which the Facility does not wand reserves the right to assert in administrative, civil or criminal claim, a or proceeding. The Facility offers response, credible allegations of compland plan of correction as part of its one efforts to provide quality of care to resid	n or plan aiver view, ation vaive any ction s its lance going
	11:20 a.m. until 1:4 of three incontinend residents #1, #2, ar appropriately provide residents. Skin observations and rehowever, resident # observations during the observatio	e: ucted on May 19, 2010, from 5 p.m., during the initial tour, ce care observations on nd #6, revealed staff ding incontinence care to the servations were also ne incontinence care evealed no broken areas; #2 was slightly reddened. The g the initial tour revealed the	IRE		TITLE	(XE) DATE
LABORATOR	DIRECTOR'S OR PROVIDE	\sim 1		_	6/9/10	. •

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient-protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ND HUMAN SERVICES					APPROVED
CENTER:	S FOR MEDICARE &	MEDICAID SERVICES			.,	OMB NO	. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PRÓVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		185094	B. WING	3		05/19	9/2010
NAME OF PR	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		ļ
0101145		the state of the s		260	SOUTH MAYO TRAIL		1
SIGNATUR	RE HEALTHCARE OF PI	KEVILLE		Pli	KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS - REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	Continued From pag	e 1	F	312		-	
	Restorative Aide and	LPN #1 also providing		1		ļ	ļ
	incontinence care to	, ,		'_			
				F	312 483.25 (a)(3) ADL CARE	PROVIDE	D
	Interviews conducted	d on May 19, 2010, from		Г	OR DEPENDENT RESIDENTS		
	11:20 a.m. until 1:45	p.m., during the initial tour,		ď	Corrective Action for Resident(s) Affordad.	
	with residents #2, #5	i, #6, and #12, and resident		F	Residents #2, #5, #6, #12, and #4	i Anected:	
		revealed there was not	İ	r	eceiving the necessary services	to maintai	y n
		de incontinent care as	ļ	g	good nutrition, grooming, and pers	sonal and ora	al I
	-	ents. The interviews revealed		h	lygiene. Residents are maintai	nina persona	al İ
	1	nard as possible, however,		h	lygiene, through timely incontine	ence care, a	s
	l	le incontinence care timely		ir.	ndicated by the interventions esta	blished in th	е
		d to lie in urine for extended		ir 44	ndividual care plan of care for res	idents #2, # <i>5</i>	5,
	1	esident #2 reported on May 6,		#	6, #12, and #4.		
		care was provided at 6:30	İ	H	low the facility will act to prote	aat maaideet	_
		not provided again until 2:15 was not enough staff working		ri	similar situations:	sct resident	s
		nt pointed to the resident's			bowel and bladder assessn	nent will h	_
	1	en asked how the resident		C	ompleted on all residents; a	nv resident	s
		ident #2 reported becoming		re	equiring a three day voiding pat	tern per thei	ir
		to lying in urine for an		b	owel and bladder assessme	ent will be	e
		ime. Resident #4's family		C	ompleted by 6/25/10. The three	e day voiding	g
	,	the family member had to		þ	attern will be completed by licens	ed nurse and	d
		May 19, 2010, because		P	N.A. team members and evaluestorative nurse. A review of each	uated by the	e
		h staff due to a call-in and		W	rill be conducted to ensure that	acri care piai	n
	the resident's brief v	vas saturated with urine.	<i>'</i> ·	to	pileting plan matches their care pla	ine resident: an by 6/25/10	S 1
		d that on May 18, 2010, the		Α	ny changes indicated by this re	eview will be	,. D
		om therapy at 10:30 a.m., and		in	nmediately addressed with an ι	pdate of the	e
	informed the staff th			C	are plan and the C.N.A care plan.	,	
		ded incontinence care.	1	_			
	•	id not provide incontinence		[]	he interdisciplinary team will	interview al	I
•		until 2:30 p.m. Resident #5		re	esidents who are interviewab	le and the	€
	'	on the wall and said the		1€	esponsible party for all residents are concerns and care needs. Th	in regards to) ''
		rait with the clock. This		h	e completed by 6/25/10. Any cor	its tealem Mil	
		sed by resident #5's sitter.		a	ddressed immediately.	ICCLUS WIII DE	= .
	i	reported being left on a		٠.,	l		1
		urs on the night shift but akdown. Resident #5 stated a					
		akdown. Resident #5 stated a it both incidents but nothing					,
	1	t #6 stated there was not	-				
	THE PROPERTY OF THE PROPERTY O	the states alone traction			i		1

		ND HUMAN SERVICES					APPROVED
CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				1	. 0938-0391 T
STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPL LDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		185094	B. WI	√G		05/19	2/2010
NAME OF PR	OVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
TE THE COT TO				1	60 SOUTH MAYO TRAIL		
SIGNATUR	RE HEALTHCARE OF PI	KEVILLE		PI	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	¹IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	lTD BÉ	(X5) COMPLETION DATE
F 312	enough staff to assis bathroom so the resito the bathroom to ke Resident #2 stated a aware of incontinence timely and of the staff resident called the A and told her and the resident. However, timplement any corresident conducted p.m. until 4:45 p.m., and #7 revealed incomplement and to be performed every were incontinent. The facility frequently, to enough staff to provide two hours. The staff mealtime, which take was only one assistatincontinence care at interviews revealed residents on the Social assistance staff was incontinence care duting the test worse over the more leight-hour shift because the staff to provide the inother duties required SRNAs #3, #4, #6, a residents' clothing/b during the incontinence.	the resident to the dent ambulated unassisted sep from being incontinent, dministrative staff was made e care not being provided fing shortage because the dministrator on the phone Administrator hung up on the he Administrator failed to ctive actions. I on May 19, 2010, from 2:45 with SRNAs #2, #3, #4, #6, ontinence care was required by two hours for residents that the interviews revealed the almost daily, did not have de incontinence care every frevealed that during es two to three hours, there and on the floor to provide and answer call lights. The that due to most of the ath wing requiring two-person	F	312	Measures to prevent reoccurre All licensed staff will be monitoring residents while may passing medications to ensure needs are being met. All licensed and being in serviced process for maintaining periocess.	in serviced aking round e that residensed staff of regarding round are plan. In regarding the according verse effect censed staff residents residents residents are chedule, that e rounding esidents had to their plan and available round available round available.	s or lents and the iene, care This how care ce_of to s of f and powel ights, a and ill be ent to e being e Unit g every ve had of care. will be punding
	at times residents w	rait four hours to receive SRNA #6 stated that resident					

#2 takes water pills and constantly dribbles and

		ND HUMAN SERVICES		100000000000000000000000000000000000000	FOF	ED: 06/02/2010 RM APPROVED
STATEMENT	S FOR MEDICARE & DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	ETED
		185094	B. WING		05	C /19/2010
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COE		
	RE HEALTHCARE OF PI	KEVILLE		260 SOUTH MAYO TRAIL	<i>,</i> _	
				PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From page	e 3	F3	12		
	hours. SRNA #7 state wheelchairs during the soaked in urine frequence was any corrective action. An interview conduct p.m., with the Staff D (SDC) revealed residing any continence care ever reported monitoring in week by auditing 20 verify the residents we stated the audits were different shifts. The had not found any procare. The SDC state calls in then one of the team gets pulled to we Wednesday, May 19 called in and the show Wednesday, so there assistant pulled to the until later that aftermorame in a few hours. An interview conduction, with the Direct the facility staff was incontinence care to two hours. The interview of a list of residence of the sound of the staffing shortage.	ne day were also found pently. The interviews we staff was aware of the wever, failed to implement s. ted on May 19, 2010, at 4:05 development Coordinator dents were to receive fery two hours. The SDC incontinence care once a percent or 16 residents to were clean and dry. The SDC reperformed every Friday on interview revealed the SDC roblems with incontinence fed that if a nursing assistant the assistants on the shower work the floor. However, on the county and a substant on additional nursing file South wing for coverage from when a nursing assistant fearly. Ited on May 20, 2010, at 9:00 or of Nursing (DON) revealed required to provide incontinent residents every		Monitoring of Corrective The DON and the unit may of residents monthly to expended accurate established by the resident and Social interview 20% of resident responsible party to ensure unable to carry out are receiving the necessary good personal hygiene. The reported to the quality monthly for three months and follow-up as indicated. Completion date: 6/25/1	anagers will revie ensure interventic ately and timel dents care plan. I Services Direct lents and/or res cure that resident activities of daily ary services to many assurance comes s for recommend	ons are ly, as The tor will ident's is who viving aintain

		ND HUMAN SERVICES					MAPPROVED
CENTERS	S FOR MEDICARE &	MEDICAID SERVICES	<u> </u>				T T
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	ED
		185094	B. WA	√G		l .	9/2010
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF PI	KEVILLE		i i	260 SOUTH MAYO TRAIL P!KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC	ΞIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	required the assistant incontinence care. The facility administrative on May 20, 2	e 4 ne incontinent residents nce of two staff persons for ative staff timed the meal 1010, and verified that meal an hour and 45 minutes to	F	312			
F 353 SS=E	2010, revealed the retwo hours to receive on April 3, 2010, and requested incontine. The grievance form questioned and the minutes to get to resunother resident.	#2's grievance dated April 5, esident reported that it took requested incontinence care if one hour to receive nce care on April 4, 2010, revealed the SRNA was SRNA said that it took 30 sident #2 due to being with	F	F 35	3		
	provide nursing and maintain the highes and psychosocial w determined by resid individual plans of c. The facility must pronumbers of each of personnel on a 24-b care to all residents care plans: Except when waive	ve sufficient nursing staff to related services to attain or a practicable physical, mental, ell-being of each resident, as ent assessments and are. Evide services by sufficient the following types of a pour basis to provide nursing in accordance with resident d under paragraph (c) of this arses and other nursing		-	F353 483.30(a) SUFFICI NURSING STAFF PER CARE Corrective Action for Resident(Residents #2, #5, #6, #12, and #receiving the necessary service maintain the highest practice mental, and psychosocial well-resident, as determined the assessments and individual presidents are maintaining persidents are maintaining persidents are maintaining staff, as indicated by the established in the individual care presidents #2, #5, #6, #12, and #4.	s) Affected 44 are curre es to attain able physic being of eacy resider lans of case on all hygie es provided	ntly or cal, ach nt's are. ne,
	Except when waive	d under paragraph (c) of this					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM-APPROVED

PRINTED: 06/02/2010

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

C

B. WING

		185094	B. Wit	1G		05/19	/2010
	OVIDER OR SUPPLIER	KEVILLE		26	EET ADDRESS, CITY, STATE, ZIP CODE 50 SOUTH MAYO TRAIL IKEVILLE, KY 41501	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	nurse to serve as a coduty. This REQUIREMENT by: Based on observation review, it was determine provide nursing and attain/maintain the his	ust designate a licensed harge nurse on each tour of is not met as evidenced in, interview, and record ained that the facility failed to related services to ghest practicable physical, ocial well-being of each		353	How the facility will act to proin similar situations: The facility will ensure that the nursing staff to provide nursing services as determined by reside and individual plan of care. In massignments, if assigned staff provide services according to p C.N.A. will report to licensed nursing the shift that an issue is licensed nurse will facility assistance by actively assisting alerting administrative staff who sufficient nursing staff is alloced.	ere is sufficence and releast assessment assessment of care areas	sient ated ents N.A. e to the time The diate nd/or that
	assessments and ind Interviews with resid- revealed there was r nursing staff to provi- incontinence care. T residents frequently more to be provided an insufficient amount	itividual plans of care. ents and nursing staff not a sufficient amount of de residents with the required the interviews revealed had to wait four (4) hours or with incontinence care due to nt of staff.			care. A bowel and bladder assess completed on all residents; requiring a three day voiding a bowel and bladder assess completed by 6/25/10. The the pattern will be completed by lice C.N.A. team members and expression of the conducted to ensure the toileting plan matches their care	pladder assessment will be all residents; any residents day voiding pattern per their dder assessment will be 15/10. The three day voiding mpleted by licensed nurse and evaluated by the A review of each care plant to ensure that the resident's	
	The findings include: Observations conducted on May 19, 2010, from 11:20 a.m. until 1:45 p.m., during the initial tour, of three incontinence care observations on residents #1, #2, and #5, revealed staff appropriately providing incontinence care to the residents. Skin observations were also performed during the incontinence care observations and revealed no broken areas; however, resident #2 was slightly reddened. The observations during the initial tour revealed the Restorative Alde and LPN #1 also providing incontinence care to the residents. Interviews conducted on May 19, 2010, from				Any changes indicated by this immediately addressed with a care plan and the C.N.A care plan and the C.N.A care plan and the C.N.A care plan and the C.N.A care plan and the C.N.A care plan and the care interview responsible party for all reside care concerns and care needs be completed by 6/25/10. Any addressed immediately.	s review w n update o an. vill interview wable and nts in regar This revie	ill be f the v all the ds to w will

		ND HUMAN SERVICES					M APPROVED D. 0938-0391
STATEMENT C	S FOR MEDICARE & DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SU COMPLET	RVEY FED
		185094	B. WIN	G		1	C 19/2010
NAME OF PR	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUR	RE HEALTHCARE OF PI	KEVILLE			SOUTH MAYO TRAIL KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	#4's family member in enough staff to proving needed by the resident the staff worked as how was unable to provice	, #6, and #12, and resident revealed there was not de incontinence care as ents. The interviews revealed hard as possible, however, le incontinence care timely	F	353	Measures to prevent reocci All licensed staff and C.N.A.' regarding the process for m hygiene, specifically providin according to the residents	s will be in sentaintaining pers g incontinence care plan	sonal care This
	amounts of time. Re 2010, incontinence of a.m., and then was r	d to lie in urine for extended esident #2 reported on May 6, care was provided at 6:30 not provided again until 2:15 was not enough staff working			education will include instructo perform incontinence care schedules are established, providing incontinence caschedule, and potential a	, how resident the importance are according dverse effects	care e of to
	clock on the wall wh timed the care. Res raw and irritated due extended period of t member stated that clean resident #4 or	nt pointed to the resident's en asked how the resident ident #2 reported becoming to lying in urine for an ime. Resident #4's family the family member had to May 19, 2010, because			delayed incontinence care. C.N.A.'s will also be educate and bladder programs and abuse and neglect, custom completing assignments. provided by the DON and the Coordinator to be completed	ed regarding be residents right residents right residents right residents right residents reside	owel ghts, and
	the resident's brief vertical Resident #5 reporter resident returned from informed the staff the incontinent and need However, the staff of care to resident #5 pointed at the clock	gh staff due to a call-in and vas saturated with urine. d that on May 18, 2010, the om therapy at 10:30 a.m., and le resident had been ded incontinence care. lid not provide incontinence until 2:30 p.m. Resident #5 on the wall and said the			Monitoring of Corrective Ac The DON and the unit manag of residents monthly to ensur- being provided accurately established by the residents Administrator and Social Se interview 20% of residents responsible party to ensure are unable to carry out activ	ers will review are interventions and timely, are plan. Trices Director and/or residents of daily lifes of daily lifes of daily lifes of daily lifes.	are as The will ent's who
	incident was witnes Resident #5 further bedpan for three ho denied any skin bre nurse was told about was done. Resider	vait with the clock. This sed by resident #5's sitter. reported being left on a urs on the night shift but akdown. Resident #5 stated a ut both incidents but nothing int #6 stated there was not			are receiving the necessary s good personal hygiene. The reported to the quality assimonthly for three months for and follow-up as indicated. Completion date: 6/25/10	he results will urance commi	be ittee
	to the bathroom to Resident #2 stated	ist the resident to the sident ambulated unassisted keep from being incontinent. administrative staff was made ace care not being provided				·	

		MEDICAID SERVICES					0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR' COMPLETE	D
		185094	B. WIN	۹G		05/19	;)/2010
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>		1	REET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATUE	RE HEALTHCARE OF P	KEVILLE			260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 353	resident called the A and told her and the	g shortage because the dministrator on the phone Administrator hung up on the the Administrator failed to	F	353	3		
	p.m. until 4:45 p.m., and #7 revealed inco to be performed eve were incontinent. The	d on May 19, 2010, from 2:45 with SRNAs #2, #3, #4, #6, ontinence care was required ry two hours for residents that he interviews revealed the almost daily, did not have			,	<u> </u>	
	enough staff to prov two hours. The staf mealtime, which tak was only one assist incontinence care a interviews revealed	ide incontinence care every f revealed that during es two to three hours, there ant on the floor to provide nd answer call lights. The that due to most of the				·	
	assistance staff was incontinence care d #3 stated that the st worse over the mon hard to provide thre eight-hour shift becastaff to provide the	uring the meal service. SRNA affing shortage had been th. SRNA #4 reported it was e incontinence rounds in an ause there was not enough incontinence care and all the					
	SRNAs #3, #4, #6, residents soaked w incontinence round a timely manner. S residents waited for incontinence care. #2 takes water pills needs incontinence two hours. SRNA#	s due to not being changed in RNA #6 reported at times					

soaked in urine frequently. The interviews revealed administrative staff was aware of the

		VD HUMAN SERVICES				,	M APPROVED	
CENTERS	FOR MEDICARE &	MEDICAID SERVICES	- 1			I	D. 0938-0391	T
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLET	TED	1
		185094	B, WN	G	Marine Control of Marine Contr	4	C 19/2010	
NAME OF PR	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
SIGNATUR	E HEALTHCARE OF PI	KEVILLE			VILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 353	Continued From pag staffing shortage, hor any corrective action	wever, falled to implement	F	353				
	p.m., with the Staff E (SDC) revealed reside incontinence care everyored monitoring week by auditing 20 verify the residents we stated the audits we	ted on May 19, 2010, at 4:05 Development Coordinator dents were to receive very two hours. The SDC incontinence care once a percent or 16 residents to vere clean and dry. The SDC re performed every Friday on						
	had not found any procare. The SDC state calls in then one of the team gets pulled to we wednesday, May 18 called in and the show wednesday, so there assistant pulled to S	interview revealed the SDC roblems with incontinence ed that if a nursing assistant he assistants on the shower work the floor. However, on 0, 2010, a nursing assistant ower team does not work on the was no additional nursing south wing for coverage until when a nursing assistant is early.				-		
	a.m., with the Direct the facility staff was incontinence care to two hours. The inte	incontinent residents every						
	requiring incontinent list revealed that 23 required the assistatincontinence care.	d there were 25 residents ace care every two hours. The s of the incontinent residents ance of two staff persons for		The state of the s				
	The facility adminis	trative staff timed the meal			·			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVE OMB NO. 0938-039		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		185094	. B. WING 05/19/201				
	OVIDER OR SUPPLIER	NKEVILLE .	3 1 100 1	26	EET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH MAYO TRAIL KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN			PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFIGIENCY)	FION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 353	services lasted from two hours. A review of resident 2010, revealed the in hours to receive red April 3, 2010, and of incontinence care of grievance form rever questioned and said	ge 9 2010, and verified that meal an hour and 45 minutes to #2's grievance dated April 5, resident reported it took two quested incontinence care on ne hour to receive requested n April 4, 2010. The saled the SRNA was that it took 30 minutes to get to being with another resident.	F	353			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES